Chapter 4: Local Systems Supporting and Serving our Citizens and Communities

Resources are organized into a system intended to support and serve our citizens. These resources include a local public entity -- a local management entity (LME) that is responsible for leading and managing the community system. Other organizations and individuals constitute the system providers of supports and services. The manager and providers that make up this system are referred to jointly as the "specialty system." Also, naturally occurring community resources provide opportunities for people with disabilities to fully enjoy full community citizenship. These resources include religious, civic and social organizations as well as other public partners. The community resources taken together with the specialty system are referred to as the "community system."

At the local level, the manager and provider specialty system is composed of public entities, private non-profit agencies and private for-profit firms as well as individual practitioners. Each of these organizations and individuals form a collective relational enterprise that constitutes a community system for supporting and serving our citizens. Each of these organizations and individuals are committed to the values inherent in the collective nature of the community system. This includes a dedication to the key characteristics of the community system as well as the leadership role of consumers and family members, particularly as related to their formal efforts as members of the local consumer and family advisory committees (CFACs).

Key Systems Characteristics

All participant systems actors – as organizations and individuals – are expected to advance the concepts of cultural proficiency, consumerism, community and public accountability.

Cultural Proficiency

Culturally proficient systems acknowledge and respect the scope and breadth of diversity that characterizes contemporary society. People who identify themselves with a particular ethnic, cultural or religious grouping have established cultural norms or practices such as customs, language, symbolism, rituals and social or behavioral expectations. Cultural competence means that these cultural norms are recognized, accommodated and respected. Culturally competent systems, both management and provider, acknowledge and demonstrate appreciation and respect for human diversity.

Consumer Driven

This concept is often referred to as consumerism or consumer empowerment. The intention is to promote systems of support and/or services that are controlled by people with disabilities. Some models of practice may involve shared control, such as that in a psychosocial clubhouse, while

others, such as drop-in centers or consumer cooperatives, are controlled solely by people with disabilities. Some models like Alcoholics Anonymous, Schizophrenics Anonymous and peer relationship and support building are defined solely as support-oriented.

Opportunities for people with disabilities to take active participatory or leadership roles in public and private systems is a hallmark of consumer driven systems. This includes assuring that individuals are supported and accommodated, provided skill and knowledge acquisition opportunities related to their roles and responsibilities and compensated and/or recognized for their efforts.

Consumer Friendly

Customer friendly systems pay attention to issues that affect actual consumer experiences with systems of service. These issues include concerns with ease of access, staff attitudes, accommodations made for physical and other disabilities and communication throughout all aspects of all systems – from the point of entry to the point of exit. This practice requires that management and provider systems alike operate in a manner that promotes a user friendly, responsive customer service orientation in all aspects of support, services, care and treatment.

Community Benefit

The intended beneficiaries of public policy are people with disabilities, their families and communities. All other actors in this arena – managers and providers – are residual beneficiaries. Residual beneficiaries are rewarded economically as a result of supporting and serving the intended beneficiaries.

The concept of people with disabilities and their families as intended beneficiaries is easily understood. The concept of the community as an intended beneficiary is more elusive. There are seven essential aspects of the "community benefit" inherent in the public specialty system is summarized as follows:

- **Citizen Value**: People supported and served through the publicly sponsored specialty system are contributing citizens in their communities. Supporting the advancement of real life outcomes through the person-centered planning process creates opportunities for people to contribute to their communities.

- **Public Accountability**: The ultimate goal of public policy management is to both promote social justice for people with disabilities and ensure the efficient use of public resources. The leadership in the management of public policy is the responsibility of a local public entity. As a public entity, there is an expectation of operating in the "light of day." This includes responsiveness to the community and open and inviting opportunities for community participation. It is essential that the public interests be served through a local organization that is public and acts in a manner that is expected of a public entity.

- **Mission Driven Community Systems**: The system manager as well as providers of supports and services is expected to be mission driven. A "mission driven" organization is committed to advancing the quality of life of the intended beneficiaries -- people with disabilities, their families and communities. Therefore, there is no room in the system for linear self-interest driven public or private organizations. This is also a quasi-market system at best with all parties receiving public financial support, therefore the residual benefit – profit and/or margin – is limited and the monetary reward is directly related to expectations of effectiveness and economic efficiency.

- **Community Orientation and Collaboration**: The planning, implementation and management of the system are not limited to the active involvement of the specialty supports and services manager and providers. These efforts embrace the larger community-- other public and private systems. Embracing people with disabilities requires broad community participation. Therefore, the overall system includes the manager, provider and community.

- **Prevention Efforts**: The system is interested in community wellness. Therefore, prevention oriented efforts are intended to achieve outcomes that promote the health and wellness of the community.

- **Public Assurances**: Through the person-centered planning process, as an individual's personal safety is taken into account in the development of a support plan. This includes consideration of the proactive and reactive components of the crisis contingency plan. Along with the personal safety concerns are public safety considerations. There is a need to ensure that reasonable safeguards are in place where potential actions of particular individuals would result in a risk to public safety. In addition, unintended consequences of promoting the freedom of people with disabilities – such as residential instability and homelessness and interactions with the criminal justice system – are mitigated through the application of planned interventions (jail diversion programs, housing initiatives, as examples). The public manager is also accountable to the community, demonstrating the ability to develop an adequate provider network with sufficient capacity to assure prompt and easy access to services for the individual and to maintain the public safety net.

Public Accountability

The expenditure of public funds requires a commitment to the public and consumers of services for proper utilization and accountability of these funds. The state and area/county programs are accountable both to the public at large for the proper stewardship of funds and to the recipients of the supports and services purchased with public funds, to ensure that those services and supports are appropriate, cost effective **and, most importantly, result in desired outcomes**. All purchase of service contracts, financial assistance contracts or direct services through Medicaid or state support, have a commensurate accountability process – a process of accountability on behalf of the public and service beneficiaries. Medicaid and state funded services and supports are subject to regular audit review for compliance with relevant regulations. Contracts are monitored against the terms of those contracts, as well as associated requirements of the funding sources. All audit and monitoring reports are published and are matters of public record.

System reform allows for a local and state partnership for monitoring the quality and appropriateness of mental health, developmental disabilities and substance abuse services through regular monitoring visits, review of critical incident reports, and the aggregation of statewide data for trend analysis. Staff in the Division of Mental Health, Developmental Disabilities and Substance Abuse Services are identified and tasked to perform independent complaint investigations and monitoring of all components of the mental health, developmental disabilities and substance abuse services system. This monitoring, local and state, serves to assure that the funding appropriated for mental health, developmental disabilities and substance abuse services and supports is spent appropriately, and that the consumers of mental health, developmental disabilities and substance abuse services receive the highest quality care, in the most appropriate setting, and in accordance with best practices.

Public accountability is embedded in the overall system reform process – from initial planning for service delivery and administration through the actual delivery of services, follow up, evaluation and audit.

As the system evolves, a clear and unbroken "chain of accountability" will emerge. This involves a public systems partner relationship between the leadership, support and oversight role of the state system and the management of public policy role of the local public system. In turn, the public-private systems partner relationship between the local managers of public policy and the implementers of public policy – service providers – will become evident. Additionally, the system will develop a more effective and efficient set of regulatory compliance requirements as we move to systems performance and outcomes as critical drivers of improvement efforts.

Local Consumer and Family Advisory Committees

Reform requires the establishment of a specialty system that is infused with the involvement of consumers, families, and other stakeholders. Specifically, reform charges the emerging LMEs (current area or county programs) with the responsibility of forming committees of consumers and family members, known as the consumer family advisory committees (CFACs). Although the system in North Carolina has established precedents for the involvement of consumers and families in the governance of local boards, and on function specific committees of the local public system, this reform effort seeks to broaden the involvement of consumers and families as partners in ways that are durable, sustainable, and, above all, meaningful to the development of a comprehensive system of services and supports. This partnership demands a cultural change at the local and state level. The cultural shift is evidenced by the expanded involvement of consumers in the planning process, as well as the thoughtful and deliberate, selection of consumers as staff to be employed in the fulfillment of Division and LME functions. The incorporation of consumers as employees within their own service system is a deliberate attempt to ensure that, for other consumers, the experience of navigating the various service components is consistent with the vision and principles articulated in the State Plan.

At the core of the community systems are the local consumer and family advisory committees (L-CFACs). The CFACs are comprised of individual consumers and family members representing all

disability groups. CFAC members meet on a regular basis in their communities to support and communicate their concerns, provide advice and comment on all state and local plans. They are charged with the following responsibilities:

- Offer recommendations on areas of service eligibility and service array, including identifying gaps in services.
- Assist in the identification of under-serviced populations.
- Provide advice and consultation regarding development of additional services and new models of service.
- Participate in monitoring service development and delivery.
- Review and comment on the state and local service budgets.
- Observe and report on the implementation of state and local business plans.
- Participate in all quality improvement measures and performance indicators.
- Ensure consumer and family participation in all quality improvement projects at both the provider and LME levels.

Although the State Plan requires the LME to "establish a consumer family advisory committee at the onset of the local planning process," no specific guidance was given to ensure that the operational procedures and the intended outcomes were understood. This section provides guidance to the field regarding the selection of CFAC membership, as well as outlines the responsibilities of all parties during the initial phase of development prior to LME certification. It is anticipated that during the years following certification as an LME, the local CFAC will develop a greater degree of operational self-sufficiency evidenced by a significantly reduced dependence upon the support of LME staff in the areas of decision making and self-governance. The LME is expected to accommodate disabilities with supports, which may include transportation, respite care and stipends as well as information, training and mentoring as needed for the committee throughout the pre and post certification periods. The CFAC will have a budget to manage for their supports.

Area authorities or county programs, whose current practices and ongoing relationships with the CFAC are inconsistent with the intent of the guidance published here, must develop a plan of corrective action prior to any level of certification as an LME. The LME's acknowledgement and compliance with the guidance published here should be incorporated in further developments of the strategic plan.

CFAC Guidelines

- **Governance** -- The CFAC has the right of self-governance, just as individuals have the right of self-determination, but does not have authority to make decisions or speak on behalf of the local governing entity.

- **Accountability** -- The CFAC is accountable to the governing authority, the community and constituency it serves. The CFAC is also responsible for maintaining a balance in representation of its membership.
- **Advocacy** -- The CFAC has the responsibility to represent all disability groups as well as those of different ethnic/cultural backgrounds.
- **Influence** -- The CFAC role is one of "constructive partner" with the LME in the implementation and management of public policy, as adopted by the governing authority.
- **Knowledge** -- The CFAC has an obligation to inform, to educate, and to support its membership, the state level CFAC as well as the local constituency, through it's own advocacy efforts.

History: Selection of Membership

The LME is charged with the responsibility of establishing the CFAC. The selection process has been a local decision and may have been initiated by the Area Director, who solicited names from local advocacy groups, county commissioners, community groups and in some instances encouraged self nominations (consistent with criteria identified in the state plan) for submission to the governing authority. Once the selection process was complete, members were appointed often 12-15 in number.

Although the actual terms of current members vary across the state, it is the intent of this communication to direct the local governing authority to limit current terms (not current members). Current terms should coincide with the occurrence of the following events -- 90 days after the date of initial or conditional LME certification, but no later than 1/1/04. The decision to set terminal dates is designed to coincide with the development of a relational agreement leading to greater self-direction of the CFAC.

LME-Pre/Post Certification

- The Governance Board and CFAC will ensure that by-laws or operational guidelines are developed and adopted which will designate the selection and appointment process, terms of service, number of members and determine other procedural issues.
- The Board will direct management to assign staff to the committee as liaison and support.
- The LME management and CFAC will jointly prepare periodic reports to the governing board, which include the cost of operation of the committee.
- A relational agreement will be jointly developed and executed.

LME-Post Certification

The intent is for the CFAC to become a fully functioning, consumer directed committee. The roles and responsibilities of the committee are delineated in the State Plan and may be reaffirmed in the

agreement. Local agreements will dictate the type and degree of support needed by the CFAC during the post certification period. The Division shall consult with the LME and local CFAC when it is determined that the extent and duration of the support is inconsistent with the intent of the State Plan. Constructive partner means the relationship between the parties must be constructive as they share a common objective.

A copy of a "Relational Agreement" containing the essential elements of the arrangement between the LME and CFAC is provided as appendix B. The document may be amended only if the additions do not detract from these essential elements.

Local Management Entities

A local management entity (LME) is a county program or public authority that is responsible for the management of public policy for the citizens the system is intended to support and serve. The primary functions of an LME as defined in legislative and administrative planning documents are:

- General Administration and Governance.
- Business Management and Accounting.
- Information Management Analysis and Reporting.
- Provider Relations and Support.
- Access Line, Screening, Triage and Referral.
- Service Management.
  - Utilization Management and Authorization.
  - Service Coordination.
    - Care Coordination.
    - Community Collaboration.
- Consumer Affairs and Customer Services.
- Quality Improvement and Outcomes Evaluation.

General Administration and Governance

Within any administration's organizational framework are many potential dotted lines of common support between two or more units (functions, e.g., Information Systems supporting Financial Accounting; Accounting operations supporting Provider Contracting; Quality Improvement Unit jointly conducting studies with Provider Relations and Information Systems, etc.) The LME's chief executive officer (CEO) will want to look at the specialty skill sets of staff related to specific functions and balance the scope of supervisory responsibilities with logical imperatives to combine functions that share some core technologies and specific skills in order to organize the functions for which middle management is responsible.

Overall administrative responsibilities include policy development; supervision of the chain of command; responsibility for local business plan development and implementation; LME accreditation; liaison with county governance and administration; divestiture; community development; annual review and update of the strategic plan based upon the goals of the three year Local Business Plan (LBP); and stewardship of funds and resources. While Area Programs currently perform many of these functions, the focus on outcomes will be a shift toward assurance of accountability.

Business Management and Accounting

The LME responsibilities of the functions of business management and accounting are:

- Developing and managing a resource allocation and budgeting process.
- Tracking payments to providers and payments against LME budgets.
- Monitoring and re-budgeting resources to core and target populations, savings from high cost to alternative services.
- Accounting, financial management and reporting.
- Reviewing provider services budget.
- LME Personnel and training.
- Purchasing.
- Payroll.
- Managing contracts with entities other than providers in network (e.g. facility lease).

This set of responsibilities, with the mission of fiscal integrity and efficient operations, will take a much more proactive role in forecasting funds and therefore services for citizens.

Information Management Analysis and Reporting

Information management analysis and reporting is one of the most important internal systems that enable LMEs to effectively and efficiently operate. A comprehensive management information system (MIS) collects data and manages information so that the LME can operate and analyze functions in real time. Examples of information needed by an LME may include:

- Access.
- Inpatient admissions and discharges.
- Concurrent reviews.
- Appeals and grievances.
- Claims received and paid.
- The qualified provider network.
- Populations served.

- Information and referral services (access, screening, triage and referral).
- Community education and training.
- Utilization review.
- Staff activity.
- System encounters.
- Quality improvement and audits.
- Clinical data.
- Housing data.
- Ad-hoc information.

The LME will determine the potential to contract with vendors for this function or develop internal capacity for these operations.

Responsibilities would also support all telecommunications equipment needed to link client access screening, utilization management and budget management functions with the provider network. Within this function estimates were made of the efforts required to extract data and produce a number of routine management reports each month. Linking the LME to the Qualified Provider Network (QPN) through automation is a critical element to effective operations as well as enhancing the relationship with service providers.

Provider Relations and Support

One of the goals of system reform is to promote organizational cultures that improve the quality, effectiveness and efficiency of services through the adoption of best business practices for program management and operations. In a buy-sell arrangement, there is typically a need to express formal relationships and expectations between systems through formal written agreements, contracts or memoranda of agreement/understanding.

In order to ensure adequate capacity of the provider network to serve the target populations living within a LME's service area, the LME needs to determine capacity. This process involves:

- Evaluating the adequacy of its capacity and analysis of service gaps.
- Developing the provider network.
- Recruiting new providers providing services that demonstrate best practice, as needs are identified and confirmed. These providers should demonstrate real and sustainable commitment to the overall welfare of the community.

The LME will continually evaluate their network capacity. In determining the optimal size and composition of its provider network, the LME should consider the factors listed below within the context of responsible public stewardship of funds and the need to safeguard potential conflicts of interest.

- Internal evaluation of network capacity/competencies.

- Consumer/stakeholder input (obtained no less than annually via previously mentioned avenues).
- Data collection and analysis.
- Prevalence rates.
- Service utilization rates.
- Geographic distribution of the population (30/30 rule, that is within 30 miles or 30 minutes).
- Demographic characteristics and special needs of the population (ethnic distribution, age breakdown, etc.).
- Need to optimize choice of providers.
- Emergence of new treatment technologies.
- Commitment to encouraging consumer-owned and consumer operated services.

The capacity evaluation, which contains a series of recommendations regarding areas where additional providers are needed, are folded into a network development plan LMEs identified in the needs assessment and should become strategic goals for each fiscal year.

Based upon the network development plan, if there is a need for new providers to be added to the network this can be done in several ways. The network may be opened to any willing and able provider who meets standards, not requiring a Federal procurement process, or existing providers may be accredited for additional services to meet the need, also not requiring a Federal procurement process. The provider network should be developed to ensure that at least two providers are available for each type of service. Exceptions are made in the following circumstances:

- Recruiting an additional provider will entail significant overhead/fixed costs with insufficient demand to support additional costs.
- The service is so specialized that only one option exists in the service area.
- It is important to contract with a sole provider in order to maintain a single entry point for services, reduce confusion and/or streamline access.

The network development plan serves as a mechanism for analysis of the factors listed above and yields recommendations regarding the need for additional providers. This plan provides the framework for network development activities to occur over time to ensure that an optimal network is in place during each fiscal year. This plan should be reviewed and updated on an annual basis.

As the LME develops its provider network, it needs to ensure it is structured so that providers do not gain economic advantage by making referrals or care coordination decisions, therefore, certain firewalls must be established. This is especially important to consider for case management providers who may also provide other services in the network. When a case management provider seeks privileges for another service, the LME may credential them to provide this service under the

condition that they can not treat a consumer simultaneously in case management and another service.

- The LME should track referrals made by case managers and access center staff to look for/address patterns that may indicate certain providers are receiving a disproportionate share of referrals based on personal staff preferences.
- The LME should encourage the development of consumer-owned and operated services. In order to maximize the success of such endeavors, it is important to phase these services in and provide adequate supports to ensure smooth start up.
- The LME must also continuously review promising advances in clinical treatment. Assuming research has been done to demonstrate with empirical evidence the value of the approach, a decision may be made to pursue a particular clinical advance and operationalize it in the provider network.

Access Line, Screening, Triage, and Referral

Systems entry (screening, triage and referral or STR) should assure ease of access organized through the LME in order to respond to community members as quickly and accurately as possible. This system includes a brief screening function in order to determine the urgency of the situation so that the type of response is the most effective route to services. Key components and considerations of this responsibility are as follows:

- There is a statewide number, which is staffed to read electronically the caller's area code and telephone prefix and automatically route that call to the appropriate LME. Each LME operates (or may contract for) an access line that is staffed 24/7 with live, trained persons. These lines receive calls routed from the statewide server and calls made directly to local access line.
- Consumers and providers will have telephone access with a live person to respond with the ability to screen, triage, and refer. STR is available 24/7 with a live person answering the telephone, TTY for individuals who have deafness or have a hearing impairment, and with Foreign Language Interpretation capabilities.
- Primary questions for Screening, Triage, and Referral (STR) are as follows:
  - Is there a MHDDSA need or not?
  - If there is, is the need urgent, emergent, or routine?
- Consumers should not be required to undergo multiple intakes or screenings. Consumers need to get to the point of assessment and service as quickly as possible. The goal is to avoid duplications of both the screening and assessment functions.
- When a consumer presents in person at a service provider and has not been referred by the LME, the provider should contact the LME access center to secure authorization to perform an assessment. If the consumer telephones the service provider directly, the provider should link with the LME while the consumer is on the line.
- Inherent in screening is the function of referral, especially for those who have no MHDDSA need, and for those with needs that are appropriate for further assessment.
- STR is performed by trained staff that is supervised by an on-site clinician.

- One hundred percent of new consumers experience the screening function. Current consumers are not required to under go screening to continue with current service providers, until a new Person Centered Plan is developed with consumer knowing a range of choices.
- STR process is standardized, performed according to consistent statewide protocol (by script with probes for safety first, urgency, etc.). Division promulgates standards for screening (including performance standards).

Systems access efforts will result in determining if an individual is in an emergency condition or if the issues would be best categorized as urgent or routine. The responses to these types of conditions are briefly described as follows:

Callers with Emergent Needs (Crisis)

- Caller is immediately "patched" to the Crisis Response System for telephonic clinical triage. LME screener remains on the line until the crisis response system has engaged the caller.
- Crisis Response System is developed by LME and may involve several models of crisis response (e.g. on-call staff, mobile crisis team, clinic or facility based crisis screening). All components of the Crisis Response System are staffed by clinicians. Telephonic clinical triage of the problem to determine which type of crisis response is required.
- Telephonic crisis intervention counseling, as appropriate.
- Dispatch mobile crisis team, as appropriate.
- Mobilize site-based evaluation, as appropriate.
- Arrange for inpatient assessment and admission, or alternative hospital admissions placements.
- Liaise with local law enforcement in situations where needed.
- Maintain Crisis Plans on file for active consumers, including contact information for current case manager or primary clinician in the qualified provider network.
- After crisis resolution, move to the "linkage" point for on-going services and supports.

Callers with Urgent or Routines Needs

- Screening unit makes "active linkage" of caller to a service provider; schedules an appointment for a Clinical Assessment. LME screening staff makes a follow-up call with the individual to assess whether linkage occurred.
- Screening unit is a proactive response system that promotes wellness, illness self-management and support, and is responsive to consumers and families calling in effort of preventing a current situation in becoming an emergent crisis situation later on.

Service/Systems Management

Management of services and supports involves the functions of 1) utilization management and authorization, and 2) service coordination that entails both care coordination and community

collaboration. Inherent in this function is the assurance of use of best and emerging best practices identified by the state and of the dissolution of services that do not reflect such practices. Following is a description of these functions:

Utilization Management and Authorization

Utilization management (UM)/Authorization is part of the system's overall strategy for managing service use by individuals and by the system as a whole. UM/Authorization is a management function and the responsibility of the LME. This function includes: eligibility determination, medical necessity levels of care assuring each consumer gets the right amount of care and support needed (i.e., does severity of illness match the intensity of service, service and/or plan), person centered plan authorization, and utilization review. It is the management function that assures that there is a single approved Person-centered Plan (PCP) ensuring that supports in the community are identified for each service recipient.

The UM/Authorization function with respect to service planning is to ensure, through review and approval, that the PCP is coordinated, not duplicative and to assure cost effective and positive outcomes. This function also serves to ensure implementation of the plan as authorized through the review of documentation and billing/reporting data. It is not necessary for the UM/Authorization function to have a direct relationship with the individual served. UM/Authorization activities do not include those day-to-day coordination and oversight activities necessary to carry out the plan.

Service Coordination

The mental health reform statute requires that each LME include service coordination as part of the core services function. It is based upon the core functions of assessment and referral. It is also closely related to the Provider Network Development function. At the micro level, service coordination incorporates Care Coordination as it applies to individuals; at the macro level, service coordination involves Community Collaboration.

Care Coordination

Care coordination is a Service Management function and a responsibility of the LME as part of the development of the qualified provider network. Care Coordination is periodic monitoring, typically through telephone contact with service providers, of individual consumer services. Care coordination entails performing document reviews to ensure that the PCP is being implemented and data analysis of service provision. System level interaction activities help ensure the system is consumer friendly by facilitating access.

Care coordination activities include:

- Coordinating care for people who are not in the target populations, to ensure that they have been linked with generic community support service or physician for the basic benefit supports depending upon the individual's need;
- Periodically and episodically coordinating care for a subset of the people who are in the target populations, and who are not receiving case management through a private provider organization or practitioner. This would typically occur when circumstances indicate the need for assistance during an episode of more intensive care (e.g., people receiving only therapy may have the need for some care coordination, as related to episodes of inpatient care); and
- People in the target population who require brief or episodic care coordination.

Community Collaboration

Community collaboration, also a Service Management function and responsibility of the LME, addresses service delivery barriers through the following components:

- Development of a strong and seamless network of supports and services while increasing community awareness of the benefits of services.
- A mechanism to initiate and complete an assessment of community strengths and needs in regard to service and supports within the community at large, including the delivery of services and supports reflective of best practice models.
- Development of an array of services and supports throughout the community in collaboration with generic community resources, and with the LME's qualified provider network, that is responsive to identified strengths and needs of the community. This process is ongoing as the needs of the community change, and clearly addresses strategies and interventions for increasing the capacity for services and supports reflective of best practice.
- Periodic assessment of progress in completion of strategies and interventions for increasing capacity for services and supports. This includes data collection regarding service utilization and consumer and family outcomes.
- Development of a supportive relationship with consumers and families, the qualified provider network (QPN), and community partners at large to promote services and supports that are consumer driven and culturally competent.
- Collaborate with other community partners (public and private) in an effort to advance opportunities for the involvement of people with disabilities as full members of the community, to create seamless customer friendly systems of support and to partner in shared responsibilities in order to promote responsive and efficient systems.

Consumer Affairs and Customer Services

This function is designed to provide a mechanism for consumers and all citizens to register a complaint, or appeal a decision ; assist the consumer via training, addressing empowerment, advocacy; assisting the consumer advisory board; and provide assistance to recovery, self-determination, self-help and empowerment support systems. The location of this function should

be in an area that is visible and easily accessible for consumers and citizens. Following are a brief description of some of the responsibilities.

- **CFAC Support**: This function is assigned the task of staffing the CFAC of the LME. This may entail researching various issues, seeking broad consumer feedback, administering consumer satisfaction surveys, etc.
- **Consumer Complaints and Grievances**: In the area of complaints, it is important to encourage consumers and citizens to register complaints. This reduces risk for an LME, and assures increased customer satisfaction. Complaints should be handled expeditiously, with staff having the responsibility of calling the complainant back every three days, documenting the call until the issue is resolved.
- **Advocacy**: Individuals may seek assistance from Customer Affairs for the exercise of rights as well as peer support in due process. They may create venues for expression of individual concerns or support development of consumer-run initiatives (e.g. drop-in center).
- **Customer Education**: In order to ensure that customers have a clear understanding of their condition, eligibility for service, access to service, benefits, process for payment, and recipient rights/appeals, it is important that they receive current and ongoing education and information regarding behavioral health benefits, new services and opportunities for wellness.
- **Community Relations**: Promoting public awareness, decreasing the stigma of behavioral health disorders, and enhancing a positive public image by determining a) the target audience; b) the types of information to present and disseminate (i.e., type of services, diagnosis, prevention); and c) the best way to present that information to provide a positive public image, is accomplished through the education of individuals and organizations in the community on managed care benefits, services, and access.
- **Customer Relations**: Promoting an attitude and atmosphere wherein the customer is number one is accomplished through culture and environment, raising awareness and seeking feedback from customers, clinicians, payers, and the general public on methods to better meet the needs of customers and the community. One method that can be used to seek feedback is through direct evaluation of community organizations, agencies and facilities.

The program is aimed at testing the system from the standpoint of a potential consumer accessing for behavioral health services. Telephone calls are made to monitor performance by providers on: courteousness, timeliness, responsiveness, accessibility, and ability to meet their requested need or an appropriate referral to another agency.

Initially, participants should review information from the Consumer Affairs and Customer Services for trends and for recommendations. Secondly, it is reviewed by the advisory councils for recommendations. Finally, it is taken to the Quality Improvement Council for monitoring of network/ provider performance, monitoring of trends, and for identification of process improvements. If a concern is identified through the Council with a specific provider, Quality Management follows up with the provider on an individual basis for a plan of improvement. The process for setting up this type of feedback system is outlined below:

- Review current services and access system.
- Identify customers.
- Define customer service.
- Review customer complaints and questionnaires; talk with staff, board, consumers and suppliers.
- Find out what's important to customers and list customer service values/requirements and associated measures.
- Set objectives in context of continuous quality improvement plan.

Quality Improvement and Outcomes Evaluation

Continuous quality improvement (CQI), sometimes called total quality management (TQM), is the process for achieving high marks in customer satisfaction. Mental health agencies developing and implementing continuous improvement should initially train board members, leaders and managers, staff, provider agencies and consumers in the definition and evolution of quality management. This educational process includes historical information and differences between quality assurance and quality improvement, common systems for planning and reporting, objectives of CQI, elements needed to successfully implement the process, roles and responsibilities and the quality cycle.

Objectives of CQI

An integrated business model incorporates principles and practices of quality assurance, quality planning, and continuous improvement. Quality improvement processes are required to meet various accrediting body standards, often state standards, and the Center for Medicaid Services Quality Improvement Systems in Managed Care (QISMC) standards. A plan should ensure compliance with local, state, and federal law as well as regulatory and accreditation standards. An adequate CQI plan facilitates good process design, and systematically measures, assesses, and improves organizational and provider performance to produce the best consumer outcomes and satisfaction through the effective and efficient use of resources.

The scope of a CQI program is broad in that it monitors and evaluates all consumers, providers, care settings, and types of service. Participation in CQI must be a job responsibility for all board members, customers, employees, providers and other contractors. First and foremost it is critical for the agency to identify its Customers. Internal Customers are people inside your agency who depend on you for service. External Customers are people outside your agency who depend on you for service. This might include contractors, providers, community agencies, etc. Ultimate Customers are those people for whom our services exist.

The objectives of CQI are:

- Culture change.
- Increase customer satisfaction.
- Increase employee involvement.
- Eliminate rework.
- Increase efficiency.
- Improve customer/provider relations.
- Improve teamwork.
- Improve accuracy.
- Reduce cost.
- Improve functional outcomes.
- Achieve compliance with regulations, law & standards.

Elements Needed for Implementation

The four elements required for a successful CQI program are leadership commitment, structure, systems support and education and training.

There are various ways to demonstrate this commitment including providing support, being actively involved at the individual level, sustaining activity, and involving a wide range of stakeholders. Some boards have created a quality committee as part of the board committee structure. Boards and directors should publicly recognize CQI efforts and provide adequate resources to encourage participation in the program. Top leadership must embrace the effort as well and demonstrate their active interest.

The structure necessary to implement CQI includes establishing a steering committee that incorporates all stakeholders. A monitoring and evaluation structure must be implemented and should begin with goals on the strategic plan. The third criteria for an adequate structure is the creation of improvement teams when processes are identified that do not meet established benchmarks. Those individuals with a stake in the outcome should be included on the teams. Teams should be time-limited and appropriate approvals sought for final decisions through the steering committee and perhaps the board's quality committee.

Likewise, systems must be in place that allows for active participation in the CQI process. These systems include efforts to encourage employee involvement, training and practice in teamwork, frequent communication about the results of the program and recognition of efforts, solutions, savings, and improvements. Employee encouragement and recognition must occur at the highest levels of the organization. When the program becomes stale, and it will, re-energizing it will require extra effort in this area. Finally, participants need education and training in CQI tools. Those tools include strategic planning, facilitation skills, and measurement tools.

Strategic Planning

Planning at the board and leadership level begins with an environmental scan, review of previous outcomes in the context of identifying Strengths, Weaknesses, Opportunities and Threats (SWOT) to the agency and its customers. This is generally facilitated using a brainstorming process with the ultimate outcomes being consensus on a statement of values, a mission, a vision and five or six critical success factors. Goals and action steps are derived from these factors. The Statement of Values reflects how the work is conducted and how the product is delivered. The values also suggest how internal and external interactions with consumers and stakeholders should occur. The Mission of the agency establishes why the agency exists and does not change frequently unless the organization is revisiting its purpose and considering a new line of business. The Mission states what the system does, for whom, how, and where. The Vision of the agency reflects what the agency hopes to become. This generally covers a three to five year period; and the goals would be a "stretch" for the agency to attain.

Evaluation and Outcomes Monitoring

It is critical to know how important functions will be measured. What kind of reports will be made? Are there established benchmarks or are there reputable ones available through other similar agencies? To whom will information be reported? What data is currently being monitored and what does it communicate? Without answers to these questions an agency will not be able to establish a worthwhile CQI process.

Provider education and technical assistance helps providers understand how the system works. The team conducts orientation for new providers and maintains a "Provider Manual". In some organizations, this function is carried out through a Provider Relations Team. QI staff are also available to assist providers with the development of their own CQI process, including quality improvement, data management and reporting, and compliance with standards.

The team develops and maintains a set of standards designed to assure consistent application across network providers and within the managing entity. These standards should crosswalk all state, federal, accrediting, payer, and value added local standards. Standards are reviewed annually and this team should be the sole point of contact for interpretation to promote consistency.

At least annually, the team should prepare provider profiles, wherein providers are evaluated against performance measures, utilization patterns, compliance with standards and customer satisfaction. The profiles are used for re-credentialing and contract management purposes. The profiles are made available to the general public and to consumers to assist them in making informed choices about organizations they would like to have providing services to them.

The audit, certification and accreditation coordination function assures consistent achievement of regulatory and accrediting standards. The team prepares accrediting applications and facilitates reviews. They are also responsible for the post-audit responses, plans of correction, and follow-up that are incorporated in the CQI process.

Performance measures must be evaluated across the system to capture significant trends. Performance information may be derived from audits, utilization data, demographic information, financial information, clinical record review, customer satisfaction surveys and reports from consumer and other focus groups. A system of data collection is maintained for each established indicator. Data collection is collected both concurrently and retrospectively. Sampling procedures must be established based on high risk and high volume parameters to assure randomness and representation. Key reports are pre-defined and used by the agency to make decisions and in summary format to help the organization in its annual strategic planning.

Quality process facilitation is provided across the network to achieve demonstrable and sustained improvements in care and service. The team provides technical assistance to providers. In facilitating the quality improvement team process, the team is charged with assuring that process improvement is prioritized and based upon the organization's strategic plan. They are also charged with assuring that improvements are carried out and evaluated for their value to the system. The QI team is also responsible for the support of systems teams such as the Recognition Team, the Communication Team, The Employee Involvement Team, and the Education & Training team that are necessary to support a CQI structure.

Monitoring and evaluation processes are identified by the QI team through an assessment of important organizational functions that are high volume, high risk, prone to problems, and/or critical to customer satisfaction.

Opportunities for improvement are identified through monitoring and stakeholder feedback. The recommendations for improvement are referred to the QI Council. The recommendations are prioritized based on risk factors, performance history, effect on overall network performance and consistency with the strategic plan. The committee may refer the recommendation to a standing committee that is studying an aspect of the issue or appoint a new QI team. The team is required to involve key stakeholders and that typically means consumers and at least one provider.

Some organizations use this team to perform credentialing functions to all independent practitioners and organizational providers. This includes primary source verification and a credentialing review process. In some organizations, this function is assigned to a Provider Network Team.

The QI Plan should have sub components pertaining to the committee structures:

- Risk Management Report.

- Corporate Compliance Plan.
- Credentialing Committee Report.
- Certification Review Report.
- Customer Satisfaction Plan.
- Information System/Data Integrity Report.
- Advisory Council Reports.
- Utilization Review Committee Report.
- Network Capacity and Competency Report.
- Systems Teams Reports
- Rights Report.

The leadership of the LME sets the direction and guides the process for reform. It is critical to the success of change that the governing board and staff leadership receive education and training regarding best and emerging best practices of business and service. In order for reform efforts to be successful commitment must begin at the top. During the 2002 – 2003 fiscal year, local business plans contained descriptions of area board composition. In compliance with House Bill 381, 99 percent of area programs utilized the structure set forth in 122C-118.1.Structure of area board, assuring that consumers and family members were equally represented on county/area boards. This is one example of leadership demonstrating a commitment to change.

Providers and Networks

Making sure that consumers have choices of services/supports and service providers is one of the driving forces behind the reform movement. People with disabilities need to be able to select their providers, services and supports, and also to select different ones if they find that their original choices are not satisfactory.

Choice can be looked at along two dimensions. First is the number of active providers in the network. Adequate networks will include a range of providers in each service or specialty so that people may choose from among them. In rural areas where there are very few providers, LMEs must work actively to build their networks over time. The network will be considered adequate only when opportunities for consumers and families to exercise informed choice are fully present. The option to choose is especially important when the provider works very closely with individuals on a frequent and ongoing basis. Case management and personal care services are examples. LMEs, whether they provide or contract for such services, must assure that individuals may select different people and providers if they so choose.

The second dimension of choice relates to the richness of the service and array in the regional system. Emphasis here is on a continuum of options that corresponds to the levels of service people want and need. For example, it is preferable to have a single agency that develops three

levels of supported housing/residential programs than to have three agencies that provide one single level. A person with a disability should not be forced to choose a group home when he/she is capable of living more independently. Neither should anyone be forced to opt for day activities that are static or not stimulating simply because nothing else has been developed. To provide a more robust service/support array LMEs may need to look at sharing resources and going across area/regional boundaries to enhance the availability of options. In addition, the local system must evolve in a manner in which people with disabilities, allied with others who care about them, may not only choose from among available services, but will have the opportunity to compose their own supports and services as well. The system must sustain a viable mix of services and supports. Again, developing a full array may need to take place gradually but it must be an integral part of all regional planning.

Growing out of each best practice foundation and person-centered planning is an array of integrated supports and services to support. Without this integration, including a single point of accountability, consumers will continually "fall through the cracks" of a fragmented system. This integrated service model is very distinct from a single provider practice model and in most cases closer to a multi-service agency. In some cases, all services are provided under one roof or agency (single agency model). In other cases the services needed are coordinated by a clear point of accountability through an organized comprehensive integrated community provider network system. Three types of examples of an organized system are as follows:

- **Lead arrangement:** A single provider organization is the lead entity and maintains formal relationships with a network of other provider organizations. The lead provider organization is the agency responsible for ensuring the implementation and management of the person-centered plan. As a whole, the network contains the comprehensive array of supports and services.
- **Affiliated arrangement:** A group of provider organizations formally comes together to develop a comprehensive network. This includes a range of ways to organize including the development of an administrative services organization (ASO), as an example.
- **Relational arrangement:** As part of a condition for contracting with the LME, each individual provider organization agrees to maintain a relationship with all of the other individual provider organizations in the network.

The above examples are not exhaustive. There are a variety of ways an organized system can be approached. The uniqueness of each community is the key factor considered in determining the systems configuration. In addition, the above examples are incomplete and oversimplifications.

Service definitions and provider qualifications, specified by the state, can be expected to incorporate these examples. Reimbursement mechanisms established by the State can be expected to recognize and incentivize these examples. In addition, LME provider network development responsibilities and LME responsibilities for entering into provider contracts will also reflect the specific form of the organized provider network(s) and system. The LME "network" is not in and of itself one of these examples of forms. Rather, the LME provider network is comprised of the entire panel of providers; many, if not most, will be organized in a manner similar to these examples and augmented by private practitioners, as necessary.

As LMEs proceed to divest themselves from providing direct services, they must simultaneously seek to encourage the development of new and different private provider organizations. These provider organizations must meet the characteristics consistent with the previously referenced examples. Regardless of the organized provider network system design and use, the following are the essential elements of the design:

- **Accessible**: The provider network must be organized in a manner that facilitates timely access to services and supports. Each LME will be expected to meet the standard of having services, as designated in rule, available to residents of the catchment area within 30 minutes drive time or 30 miles distance.
- **Integrated:** Each provider organization is expected to maintain relationships as part of a network responsible for delivering supports and services. The network is a constellation of provider organizations – a system. All providers that are a part of the system and receive public funds must have a formal relationship with the LME.
- **Coordinated:** All aspects of a person-centered plan are to be carried out by the provider organization in such a manner that reflects the interrelationship of each individual component of the plan.
- **Comprehensive:** A network should be comprised of a full complement of supports and services. This includes regional efforts to satisfy availability of scarce demand types of services. A system should be comprised of more than one network.
- **Community:** Each provider organization should have a viable and valued role as part of the local community and a sustainable commitment to the community.
- **Competent:** Each provider organization should demonstrate competencies as reflected through an active commitment to the foundations of a reformed system, relationships with other providers and the systems manager, exemplary application of supports and services and on-going systematic efforts of quality improvement.

Adult Mental Health

At the core of the system are the individuals or teams responsible for implementing and managing the person-centered plans; this is frequently a component of case management services. Many, but certainly not all, consumers require case management services. Many consumers with severe and persistent mental illness can benefit from blended, active, service-oriented and skill-building case management models. These services can be integrated with other services for these consumers, sometimes into a single service definition, under a reimbursement methodology that includes the case management function with payment for the other services. For example, many consumers with severe and persistent mental illness will require a form of intensive case management or will require Assertive Community Treatment (ACT).

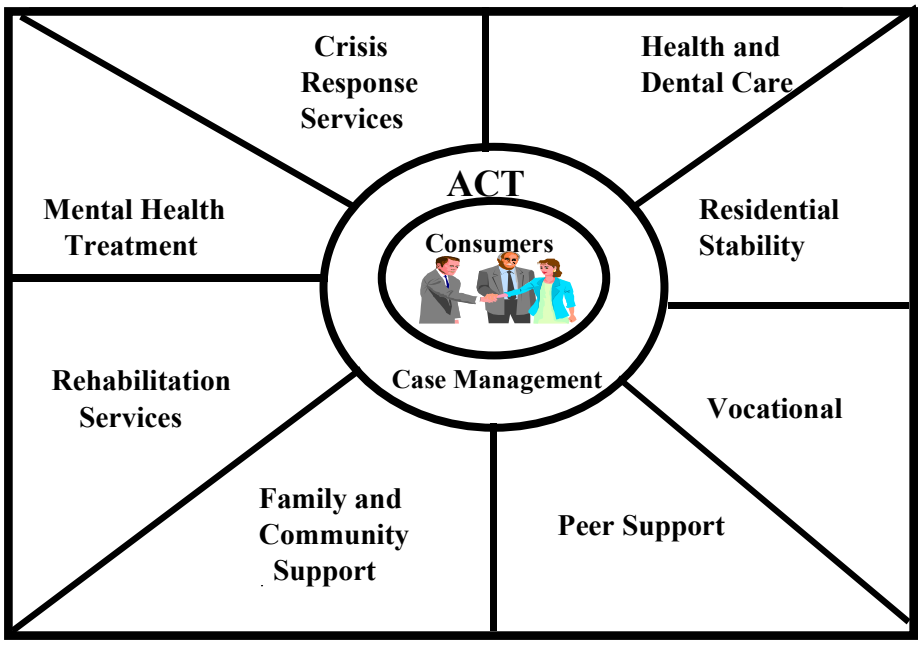
To achieve this single point of accountability and service integration, services for adults with severe and persistent mental illness are best coordinated using a single multi-service agency or multiple-agency network where the ACT team or the provider agency's case manager serves to coordinate the array of support services. The case manager is usually a member of the team. Thus, the

provider organization providing intensive case management or ACT is the ultimate accountable agency. Following required protocols (medical necessity and federal sufficiency standard, as examples), case managers and ACT teams should be empowered to make decisions and develop comprehensive treatment plans with consumers that are then submitted to the LME for approval.

The array of supports and services that are part of the organized provider network system (integrated system) fall into a number of domains:

- Mental health treatment.
- Crisis response services.
- Health and dental care.
- Housing.
- Vocational.
- Peer support.
- Family and community support.
- Rehabilitation services.

ADULT MENTAL HEALTH: INTEGRATED SYSTEM



Each dimension has a number of discrete services. These services are listed below. The Division recognizes that our current system of services does not offer all components of this array of services uniformly across the state and LMEs will not be required to offer all services in the immediate future. At the same time, the Division is working to include a number of these kinds of services in a new service taxonomy that may become eligible for federal financial participation

through Medicaid as well as state funds. This work includes clarifying service definitions, provider qualifications and reimbursement methodologies.

As Medicaid and state fund reimbursement policies are adjusted to conform to the new service definitions and as provider organizations demonstrate their capacity to provide these services, the Division expects that the local systems will include more of these providers and services. In initiating the development of the full array, there should be, at a minimum, at least one service in each dimension through their provider network (dimensions are presented in the Best Practices section of this document). This should reflect the service most consistent to the needs of the population. Continued local strategic planning should also reflect how local systems would continuously work with its provider networks to develop, over time, the array of services across dimensions.

Child Mental Health

A coordinated system of supports and services for children with behavioral and emotional disorders and their families is necessary to implement wraparound and family-centered approaches. It has long been recognized that the primary barrier to improved services for children is the lack of coordination and cooperation between child serving agencies (President's New Freedom Commission, 2002, Surgeon General's Report , 1999). Only a broad-based, community-focused service system with participation and contribution from a variety of public organizations, non-profit agencies, citizen stakeholders and parent and child advocacy organizations is needed can efficiently and effectively to respond to mental health needs of children, in the context of their families, schools, and community. A key challenge and opportunity is to break down barriers between child-serving systems and to link the reforms of the State Plan with other system reform strategies (in schools, social services and juvenile justice) to ensure a unified approach for all children with serious emotional and behavioral disturbances that is accountable to outcomes directly related to the well being of those children and families and that is consistent with national best practices (Center for Mental Health Services, National Evaluation Reports to Congress). (See President's New Freedom Commission, 2002, Surgeon General's Report, 1999.)

Better outcomes are possible for children and families when families, providers and child-serving systems work together using wraparound approaches. This can be measured by:

- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.
- Residential lengths of stay are reduced.
- Children are more likely to remain in their communities.
- The number of acute psychiatric hospital re-admissions is reduced.
- Families and caretakers provide more stable living environments for children
- Children have improved emotional stability
- Families are more involved in, and better satisfied with the care their children receive

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- Acute psychiatric hospital re-admissions are reduced.
- Families and caretakers provide more stable living environments for children.
- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.

Each child and family presents a unique combination of strengths and needs. Therefore, to be effective, those providing assistance to children and families should build upon the specific capabilities, culture and preferences of each person. When this is done, every response will be different, because every child and family is different. Each plan of care should reflect and support those differences. Providers must be able to identify the functional strengths presented by children and families even when those children and families are experiencing serious problems in their lives. In addition, providers must be able to modify their service options in order to respond quickly and appropriately to the changing needs of each child and family. Furthermore, when children and families have complex needs and are open to several human service systems at the same time, providers must be able to work collaboratively with other individuals and agencies. Children and families should have one plan and one team, regardless of the complexity of their needs.

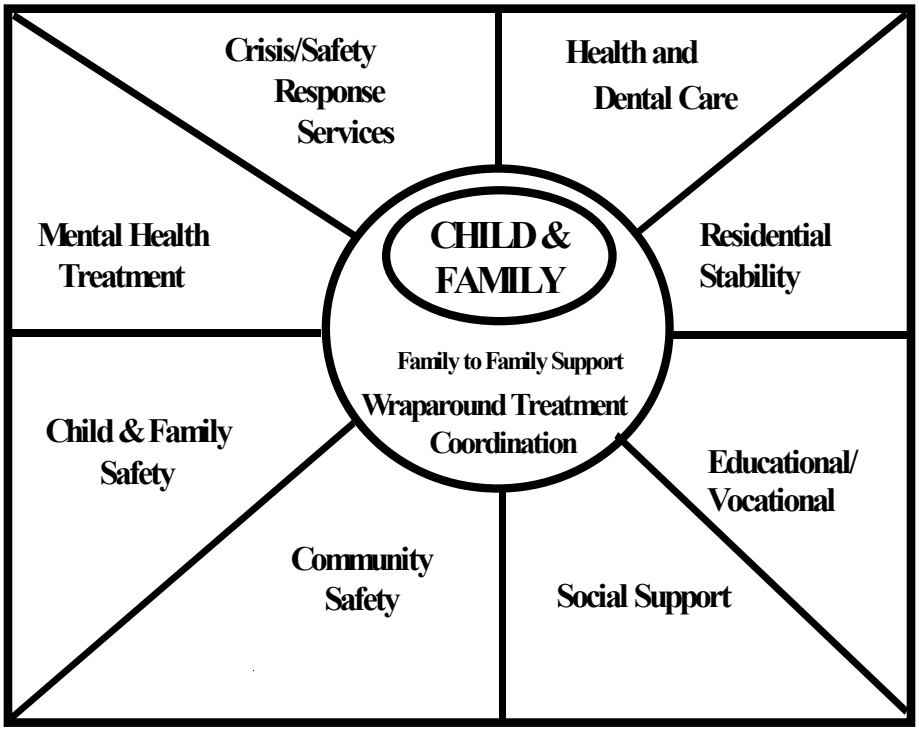
These outcomes can best be achieved by an integrated systems model. At the core of this system are the Child and Family Teams responsible for implementing and managing the family-centered wraparound plans, described previously. However, child and family teams require the active involvement and support of all the community's child serving agencies, providers and organizations. To achieve the single point of accountability needed for individual child/family outcomes and shared accountability needed for community service integration, services for children with serious emotional and behavioral needs are provided via Child and Family Teams through a multiple-agency and provider network. Each provider organization providing intensive Treatment or Resource Coordination for a given Child and Family Team is the ultimate accountable agent for individual child/family outcomes; and, each provider within the network shares accountability within the Community Collaborative. Following required protocols (e.g., medical necessity), Treatment/Resource Coordinators and Child and Family Teams should be empowered to make decisions and develop one comprehensive plan of care with the family that is then submitted to the LME, as part of the Community Collaborative, for approval. Because so many agencies, providers, and the school system are involved in the lives of children with emotional/behavioral needs, plans of care can (and should) incorporate multiple funding sources. LME approval alone is insufficient to ensure comprehensive care and avoid cost shifting.

The array of supports and services that are part of the integrated/comprehensive provider network system for children and their families fall into a number of domains:

- Family to family support.
- Mental health treatment.
- Crisis response services.

- Intensive home visitation.
- Health and dental care.
- Housing.
- Education/vocation.
- Child and family safety.
- Community safety.
- Social support.
- Neighborhood and community support.

CHILD MENTAL HEALTH: INTEGRATED SYSTEM



Each dimension has a number of discrete services. These services are listed below. The Division recognizes that our current system of services does not offer all components of this array of services uniformly across the state and LMEs will not be required to offer all services in the immediate future. Some of these services are offered by other agencies in DHHS, other Departments of state government and by private and non-profit agencies outside of government. While LMEs are not responsible for providing these services, they are expected to locate services provided by other agencies in their community and try to develop ways for clients to access these

services. At the same time, the Division is working to include a number of these kinds of services in a new service taxonomy that may become eligible for federal financial participation through Medicaid as well as state funds. This work includes clarifying service definitions, provider qualifications and reimbursement methodologies.

As the service taxonomy is developed, stakeholders will have the opportunity to have input. As Medicaid and state fund reimbursement policies are adjusted to conform to the new service definitions and as provider organizations demonstrate their capacity to provide these services, the Division expects that local systems will include more of these providers and services for children and families, working through their local Community Collaborative. This includes work the state is doing to better align funding, requirements and best practices. Local communities, however, at a minimum, offer at least one service in each dimension through their provider network. (Dimensions are presented in the Best Practices section of this document). This should reflect the service most consistent to the needs of the population. The continued local strategic planning should also reflect how the LME would continuously work with its provider networks to develop, over time, the array of services across dimensions.

Developmental Disabilities

Growing out of a self-determination orientation and person-centered planning is an array of integrated supports and services to support the individual. Without this integration, including a single point of accountability, consumers will continually “fall through the cracks” of a fragmented system.

At the core of an integrated system is the supports coordinator. The supports coordinator is part of an agency that provides supports coordination only to the particular individual. This ensures "independence" from the management entity and other systems providing a variety of supports and services. These other systems providing supports and services include traditional providers who are part of the provider network as well as non-traditional providers of supports and services. "Non-traditional" is included to be defined as individuals selected by the person with the disability to provide community supports and services, which could even include the supports coordinator. These types of relationships may be pursued through Fiscal Intermediary, Staff Leasing or Provider Systems models. The person-centered plan itself is the ultimate foundation for ensure the integration of the individuals and systems providing supports and services.

The organized provider network systems described at the onset of this chapter do not fully examine such areas as non-traditional providers. Also, because a system elects to use networking does not make it best practice. The system is not at “best practice” because it supports networks, but the system that has networks may be more likely to reflect the principles of person centered services and be outcome driven, allowing greater flexibility and choice. As in the case of best practice, while most would consider supported employment the most progressive practice, it is not in and of itself best practice. The status of a service/support strategy as “best practice” is determined by what it contributes to the consumer’s ability to achieve goals and outcomes. If a system does not achieve outcomes, it is not best practice. There are a variety of ways an organized system can be approached. The uniqueness of each community is the key factor considered in determining the systems configuration. In addition, the above examples are

incomplete and oversimplifications. An integrated system provides for means of evaluating the effectiveness of the system, including the state, local management system and providers in meeting outcomes.

Substance Abuse

The integration of services and supports to provide a system of best practice including evidence based principles of effective Substance Abuse Services and the model of comprehensive substance abuse treatment services as published by the National Institute of Drug Abuse (NIDA).

In addition to recovery and person-centered planning as the philosophical foundations for the new substance abuse system of care, there must also be a continuum of care that reflects best practice. It must be a comprehensive and integrated system of supports and services that support recovery. Without this integration, that includes a single point of accountability, consumer's will continually "fall through the cracks" of a fragmented system.

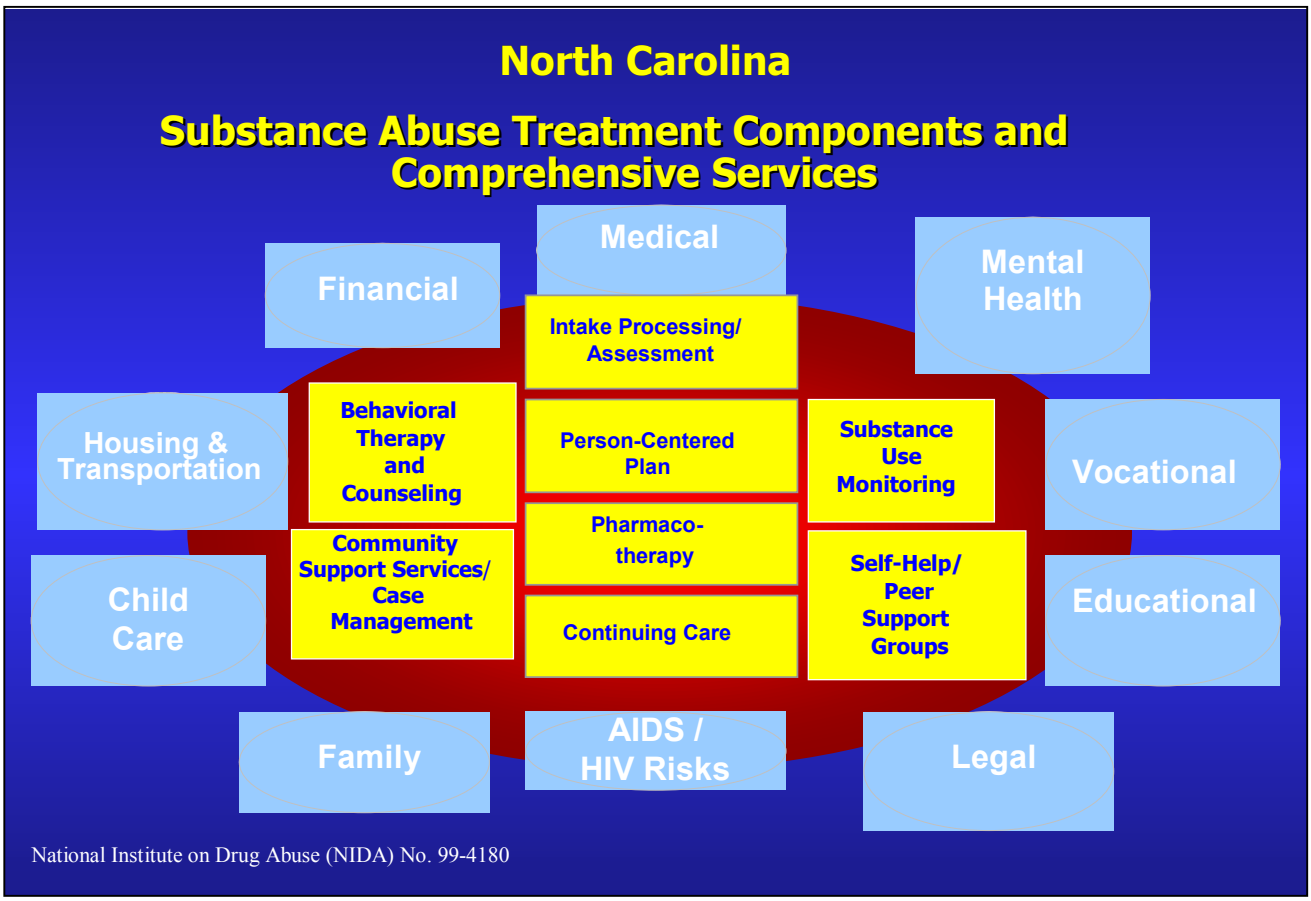
At the core of this system is the individuals or teams responsible for implementing and managing the person-centered plans; this is frequently a component of community support/case management services. Many, but certainly not all, consumers require community support/case management services. These services can be integrated with other services for these consumers. For example, many female consumers with a substance dependency diagnosis will require forms of community support services that are elements of best practice for gender specific treatment. The community support manager is usually a member of the treatment team. Following required protocols, such as medical necessity, community support managers must be able and empowered to make decisions and develop comprehensive treatment plans with consumers that are then submitted to the LME for approval.

The Center for Substance Abuse Treatment's National Treatment Plan has also identified guidelines for best practice to build a seamless system offering high quality and effective treatment. These guidelines reflect elements of the best practice service delivery system that have been integrated into the State Plan. They include:

- **Invest for results.** The wise use of resources requires investment and services that in turn must produce the desired results.
- **"No wrong door" to treatment.** Effective systems must ensure that an individual seeking services will be identified and assessed and will receive appropriate services, either directly or through referral, no matter where he or she enters the realm of services.
- **Commit to quality.** Effective treatment and services and the wise use of supports depends upon ongoing improvement in quality.
- **Change attitudes.** Significant reduction in stigma and changes in attitudes will require a concerted effort based on systematic research.
- **Build partnerships.** Effective efforts by individuals and organizations throughout the substance abuse field to work with each other and with other people and groups who share

a concern to improve substance abuse treatment will require specific encouragement and support.

Ideally, each LME will develop a comprehensive continuum of services for their constituents, the goal of which is to promote early and ongoing recovery. National Institute of Drug Abuse (NIDA) has identified an evidenced based model of comprehensive addiction treatment services which reflects the concepts of an integrated, coordinated and comprehensive community service array for substance abuse services.



Systems Development: Critical Areas of Concentration

There are many areas of systems development that is necessary for reform. In developing the Local Business Plans (LBPs), the LMEs have initiated the development of public partnerships and community and provider systems. Although concentrated efforts in all areas need to continue, housing and community hospital relationships are two areas that require increased attention.

Housing

Expanding the availability of decent, safe and affordable housing for persons with mental illness, developmental disabilities and/or substance use disorders is an area where it will be necessary to target resources – staff time, technical expertise and investment. This section provides clarification of expectations of the LMEs role in community housing efforts.

Where our constituents live is not an issue that can be addressed in isolation. It is intricately related to the work we are doing to improve our capacity to provide the depth and range of community based services necessary to support persons with serious cognitive disabilities in the community. The housing needs of MH/DD/SAS consumers, and therefore our housing efforts, must be targeted over a range of housing/residential models. The pure supportive housing model, scattered site, independent units with access to flexible support services tailored to individual needs and preferences is a recognized model of best practice. All of our housing efforts should be directed at providing consumers the opportunity to achieve maximum personal independence whether in supported living arrangements, independent living or by supporting consumers in their own homes. Within the supported housing model the clustering of independent apartments addresses the choice of many to live in proximity to others like themselves, as it maximizes opportunities for peer support and consumer direction of the housing resource. Across disability lines there is also a need for small scale structured settings, not dead end placements, but stable residential options that are designed to provide the opportunity for growth, skill building and transition to more independent living.

Under current funding and reimbursement mechanisms few of these housing options are paid for through Medicaid or Division funding. Consequently, there are few traditional providers who are willing or able to assume the housing role. Assuring availability of community housing will require that, in addition to assuring an adequate provider network, the public MH/DD/SA service system expand its capacity to support its constituents in accessing and utilizing generic affordable housing resources.

Expanding housing opportunity requires an investment of time and relationship building: first in developing connections with housing providers, both public and private, so as to maximize access to existing resources, and then parlaying these connections into new development. Housing resource development functions would include:

- Collaborating with other disability and affordable housing advocates in efforts to assure that a fair share of public resources are targeted to extremely low income persons with disabilities. This would include participating in the area's Consolidated Planning process and representing the needs of MH/DD/SAS consumers in local the Continuum of Care planning process.
- Creating an inventory of currently available housing resources accessible to consumers, families and service providers.
- Maintaining information on the unmet housing needs of persons served by the LME, prioritizing these needs and developing strategies to address them.

- Developing a positive working relationship with local Public Housing Authorities and Section 8 administrating agencies to improve access and increase the supply of these resources.
- Developing Low Income Housing Tax Credit targeting plans and then supporting the continuing relationship with development management to assure that the units remain available to MH/DD/SAS consumers and the tenants have access to appropriate services.
- Continuing administration of any current HOME or HUD Homeless Assistance grants.
- Developing and maintaining an internal wait list for consumer referrals to housing resources that have referral relationships with the LME.
- Providing local liaison to the development and operations of residential programs including Oxford Houses, 122C Supervised Living, etc.
- Engaging developers/providers as potential partners in housing development and developing a working knowledge of funding sources and how their regulations, income and population targeting, matching requirements, allowable development fees, etc. dictate how they can be combined.
- Providing education to consumers, families and service providers on accessing and maintaining affordable housing: NC Landlord-Tenant and Fair Housing law and negotiating Reasonable Accommodations.

The Division would like to incorporate what has been learned from the experience of the local housing specialists that have been funded through adult mental health. The LME should assure that the spectrum of housing needs is included within the community capacity building functions of the LME. The LME may choose to maintain this function within their administrative structure or contract with an existing or newly developed local community non-profit, including generic affordable housing providers and developers that serve the community at large. The activities of housing resource development will not be disability specific, but for the benefit of the target populations. Housing resource development staff will not be providing direct services to consumers but will work with community partners to develop a range of housing/residential capacity within the LME geographic area.

The Division intends to provide leadership on housing resource development within its new structure. In addition to promoting linkages and the exchange of information between LMEs, the Division will provide technical assistance and training on ways to maximize existing housing resources and best practice in developing residential and supportive housing services. Local LME and Division initiatives will coordinate across agency lines, at the state and local level and support DHHS efforts to speak and act collectively in our approach to the affordable housing system for the benefit of extremely low income persons with disabilities.

Community Hospitals

Local hospitals play a unique role in assisting area programs/LMEs to carry out their mission. To appreciate their importance, one only needs to consider the fact that the local hospital emergency room is, generally, the place where, by design or default, people in psychiatric crisis present. In view of this, it is expected that local community hospitals will be involved in the on-going development and implementation of the strategic local business plans. Since the advancement of

the local business plans could affect the hospitals as health care delivery systems, involvement should include the hospitals' strategic or policy level staff.

There is a great deal of reform-related emphasis in the areas of access and responsiveness, development of a comprehensive provider network and the transition from state operated facility-based services to community-based services. The following three key considerations could or should involve the community hospitals:

- **Access System:** A good number of individuals in crisis present at the community hospitals. Therefore, community hospitals, whether or not they have inpatient behavioral units, should be considered as a viable component of the communities' access system. This could include screening/evaluation, inpatient admission and alternatives to inpatient services for individuals in crisis who meet medical necessity criteria.
- **Provider Network:** Along with the inpatient/crisis services that may be offered, there are other types of community-based services that the community hospitals may have the expertise to develop or provide. Community hospitals may consider developing capacity in other community-based service modalities such as day treatment, in-home care and consultation, etc. This would facilitate the expansion of community capacity starting with the clinical expertise and existing administrative infrastructure in place at the community hospitals. The services would be expected to comport with the fidelity of best practice models in mental health and substance abuse.
- **Community Resource:** Regardless of whether community hospitals desire to be a part of the access system or provider network, they are a valued community resource. There is a need to recognize and develop a system that assures timely, and appropriate response to individuals in psychiatric related crisis who present in local hospital emergency rooms. Support from the area programs will be critical in planning for these services, and on-going local planning should reflect that community hospitals have been invited to actively participate as a stakeholder system and a service provider.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has formed a task force including representation from the community hospitals in North Carolina. The purpose of this task force is to identify and problem solve policy barriers to the valued and necessary inclusion of the community hospitals as a partner in systems reform. The efforts of the task force will include other stakeholders as relevant issues are identified. Developments by the task force will be shared with the field as they occur.

Physical Health

Many clients with mental health, developmental disability and/or substance abuse problems lack a regular medical provider despite the recognition that many of them have, or are at risk for, serious physical health problems. Many of these have poor and risky health practices include poor diet, lack of physical exercise, smoking, illegal drug use and unprotected sex. Clients are at risk for a number of poor health outcomes including HIV, STDs, hepatitis, breathing problems, etc., that predictably result in excess mortality and morbidity. Providers should actively link clients to medical providers, regularly counsel clients about behaviorally related health risks and work with medical providers to coordinate medical care with mental health, developmental disabilities and substance abuse services. Network service providers are encouraged whenever possible to

provide on-site medical services to reduce barriers to medical care. Physical health services should be coordinated across systems.